

2339

CERTIFICATE OF DEATH

Reg. Dist. No.

02312

1. PLACE OF DEATH o. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Michaels</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Navy Point</u>			
3. NAME OF DECEASED (Type or print) <u>William H. T Colbourne</u>				4. DATE OF DEATH Month <u>2</u> Day <u>9</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/18/67</u>	
9. AGE (In years last birthday) <u>91</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seafarer Tacker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Samuel E Colbourne</u>				14. MOTHER'S MAIDEN NAME <u>Charlotte Miles</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>24-30-78824</u>		17. INFORMANT <u>Miss Mary J. Colbourne, St. Michaels</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial failure</u> DUE TO (c) <u>atherosclerotic coronary heart of</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Found dead 3 AM 2-8-59</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>5-11</u> , 19 <u>54</u> to <u>2-8</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2-1</u> , 19 <u>59</u> , and that death occurred at <u>3 A</u> . M., from the causes and on the date stated above:							
ACTUAL SIGNATURE <u>Thy M. Reeser</u> M.D.				ADDRESS (Street, city or town, state) <u>St Michaels Md</u>			
PHYSICIAN'S NAME (Type) <u>Thy M Reeser</u>				DATE SIGNED <u>2-9-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/11/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Michaels Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>St. Michaels Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Doshell</u> ADDRESS <u>Boston, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 16 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G238 2-13-59 et

CERTIFICATE OF DEATH

02313

2323

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN b. <u>1 wk</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>1524 Goldsboro St.</u>			
3. NAME OF DECEASED (Type or print) First <u>LAURA</u> Middle <u>Virginia</u> Last <u>DAVIDSON</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>4</u> Year <u>1959</u>			
5. SEX <u>fe</u>		6. COLOR OR RACE <u>w</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Apr. 17, 1873</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Penna.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Leonard Swartz</u>				14. MOTHER'S MAIDEN NAME <u>Mary Writte</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>				16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>W. L. Davidson</u> Address <u>Easton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>neurosis left ventricle</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Old myocardial infarct</u> (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u></u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u></u> Day <u>19</u> Year <u>19</u> Hour a. m. <u></u> p. m. <u></u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>19</u> to <u>19</u> , that I last saw the deceased alive on <u>Feb 1, 1959</u> , and that death occurred at <u>1:15</u> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u>				ADDRESS (Street, city or town, state) <u>219 S. Washington St. Easton, Md.</u> DATE SIGNED <u>Feb 5, 1959</u>			
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>				ADDRESS <u>Easton 16, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb 7, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Easton, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice F. Newnam, Sr.</u> ADDRESS <u>Easton, Md.</u>				24a. REC'D BY REGISTRAR <u>FEB 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2324

CERTIFICATE OF DEATH

Reg. Dist. No.

02314

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>5da. 5hr</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Trappe</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Howard</u> Middle <u>H.</u> Last <u>Eason</u>				4. DATE OF DEATH Month <u>2</u> Day <u>1</u> Year <u>1959</u>					
5. SEX <u>m</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/1/77</u>			
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Samuel A. Eason</u>				14. MOTHER'S MAIDEN NAME <u>Laura Quimby</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Address</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>587.0</u> <u>Acute Hemorrhagic Pancreatitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u> DUE TO (b) <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> (b) <u> </u> (c) <u> </u>								INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u> (County) (State)			
21. I certify that I attended the deceased from <u> </u> 19 <u> </u> to <u> </u> 19 <u> </u> , that I last saw the deceased alive on <u> </u> 19 <u> </u> , and that death occurred at <u> </u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2195 Westington St Easton, Md.</u> DATE SIGNED <u>2 Feb 59</u>									
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u>				M.D. <u> </u>					
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>				ADDRESS <u>Easton 16, Maryland</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-3-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Easton, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice E. Keenan & Son</u>				ADDRESS <u>Easton, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 6 '59</u>			
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2325

CERTIFICATE OF DEATH

Reg. Dist. No.

02315

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Denton</u> ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hosp.</u>		d. STREET ADDRESS <u>R7.D #1</u>	
3. NAME OF DECEASED (Type or print) <u>Mr. Edward S. EVANS</u>		4. DATE OF DEATH <u>Feb 24 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 10, 1885</u> 9. AGE (In years last birthday) <u>73</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
13. FATHER'S NAME <u>Mr. Thomas EVANS</u>		14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Clark</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u> </u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastrointestinal hemorrhage</u> <u>540.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Gastric ulcer</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>18 days</u> <u>Unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic heart disease, Congestive heart failure</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-8</u> , 19 <u>59</u> , to <u>2-24</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2-22</u> , 19 <u>59</u> , and that death occurred at <u>11:50</u> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>202 Dover St. Easton, Md.</u> DATE SIGNED <u> </u>			
ACTUAL SIGNATURE <u>Robert W. Trever</u>		M.D. <u>202 Dover St.</u>	
PHYSICIAN'S NAME (Type) <u>Robert W. TREVER</u>		Address <u>Easton, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 27, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Denton</u>		22d. LOCATION (City, town, or county) (State) <u>Denton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. V. Moore & Son</u>		ADDRESS <u>Denton, Md.</u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	
DATE <u>MAR 6 '59</u>			

1
 This is to certify that the within and foregoing is a true and correct copy of the original as the same appears in the records of the State of New York.
 Given under my hand and the seal of the State at Albany, this 1st day of June, 1911.
 J. B. ALLEN, Secy. of State.

1. NAME OF DECEASED JAMES J. ALLEN		2. DATE OF DEATH June 1, 1911	
3. PLACE OF DEATH New York City		4. COUNTY New York	
5. CITY OR TOWN New York City		6. STATE New York	
7. NAME OF DECEASED JAMES J. ALLEN		8. DATE OF DEATH June 1, 1911	
9. PLACE OF DEATH New York City		10. COUNTY New York	
11. CITY OR TOWN New York City		12. STATE New York	
13. NAME OF DECEASED JAMES J. ALLEN		14. DATE OF DEATH June 1, 1911	
15. PLACE OF DEATH New York City		16. COUNTY New York	
17. CITY OR TOWN New York City		18. STATE New York	
19. NAME OF DECEASED JAMES J. ALLEN		20. DATE OF DEATH June 1, 1911	
21. PLACE OF DEATH New York City		22. COUNTY New York	
23. CITY OR TOWN New York City		24. STATE New York	
25. NAME OF DECEASED JAMES J. ALLEN		26. DATE OF DEATH June 1, 1911	
27. PLACE OF DEATH New York City		28. COUNTY New York	
29. CITY OR TOWN New York City		30. STATE New York	
31. NAME OF DECEASED JAMES J. ALLEN		32. DATE OF DEATH June 1, 1911	
33. PLACE OF DEATH New York City		34. COUNTY New York	
35. CITY OR TOWN New York City		36. STATE New York	
37. NAME OF DECEASED JAMES J. ALLEN		38. DATE OF DEATH June 1, 1911	
39. PLACE OF DEATH New York City		40. COUNTY New York	
41. CITY OR TOWN New York City		42. STATE New York	
43. NAME OF DECEASED JAMES J. ALLEN		44. DATE OF DEATH June 1, 1911	
45. PLACE OF DEATH New York City		46. COUNTY New York	
47. CITY OR TOWN New York City		48. STATE New York	
49. NAME OF DECEASED JAMES J. ALLEN		50. DATE OF DEATH June 1, 1911	
51. PLACE OF DEATH New York City		52. COUNTY New York	
53. CITY OR TOWN New York City		54. STATE New York	
55. NAME OF DECEASED JAMES J. ALLEN		56. DATE OF DEATH June 1, 1911	
57. PLACE OF DEATH New York City		58. COUNTY New York	
59. CITY OR TOWN New York City		60. STATE New York	
61. NAME OF DECEASED JAMES J. ALLEN		62. DATE OF DEATH June 1, 1911	
63. PLACE OF DEATH New York City		64. COUNTY New York	
65. CITY OR TOWN New York City		66. STATE New York	
67. NAME OF DECEASED JAMES J. ALLEN		68. DATE OF DEATH June 1, 1911	
69. PLACE OF DEATH New York City		70. COUNTY New York	
71. CITY OR TOWN New York City		72. STATE New York	
73. NAME OF DECEASED JAMES J. ALLEN		74. DATE OF DEATH June 1, 1911	
75. PLACE OF DEATH New York City		76. COUNTY New York	
77. CITY OR TOWN New York City		78. STATE New York	
79. NAME OF DECEASED JAMES J. ALLEN		80. DATE OF DEATH June 1, 1911	
81. PLACE OF DEATH New York City		82. COUNTY New York	
83. CITY OR TOWN New York City		84. STATE New York	
85. NAME OF DECEASED JAMES J. ALLEN		86. DATE OF DEATH June 1, 1911	
87. PLACE OF DEATH New York City		88. COUNTY New York	
89. CITY OR TOWN New York City		90. STATE New York	
91. NAME OF DECEASED JAMES J. ALLEN		92. DATE OF DEATH June 1, 1911	
93. PLACE OF DEATH New York City		94. COUNTY New York	
95. CITY OR TOWN New York City		96. STATE New York	
97. NAME OF DECEASED JAMES J. ALLEN		98. DATE OF DEATH June 1, 1911	
99. PLACE OF DEATH New York City		100. COUNTY New York	
101. CITY OR TOWN New York City		102. STATE New York	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2326

CERTIFICATE OF DEATH

02316

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>26 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>107 Blake street</u>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Grant</u> Last <u>Grant</u>		4. DATE OF DEATH Month <u>2</u> - Day <u>7</u> - Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/26/96</u>
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>auto repair</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>New Jersey</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Abraham Grant</u>		14. MOTHER'S MAIDEN NAME <u>Hattie Apple Gait</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>155-09-524</u>	
17. INFORMANT <u>Mrs. Harry Grant</u> Address <u>Easton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>CORONARY THROMBOSIS, ACUTE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTEROSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>15 MIN.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JAN 7</u> , 19 <u>57</u> , to <u>2/7</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2/7</u> , 19 <u>59</u> , and that death occurred at <u>3:20</u> A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Easton, Md.</u> DATE SIGNED <u>2/9/59</u>			
ACTUAL SIGNATURE <u>L. J. Egler</u>		M.D. <u>Easton, Md.</u>	
PHYSICIAN'S NAME (Type) <u>L. J. Egler</u>		<u>Easton, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb. 10, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Easton Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marcelle E. Newnam</u> ADDRESS <u>Son Easton, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 10 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Carling L. K.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 11, See: Birth Cert. et

2327

CERTIFICATE OF DEATH

Reg. Dist. No.

02317

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>5 hours</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hospital</u>				d. STREET ADDRESS <u>R 2D #1</u>			
3. NAME OF DECEASED (Type or print) First <u>Ralph</u> Middle <u>Edward</u> Last <u>Holland</u>				4. DATE OF DEATH Month <u>February</u> Day <u>8</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 16, 1958</u>	
9. AGE (In years last birthday) <u>3</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>3</u> Days <u>8</u> Hours <u>0</u> Min. <u>0</u>		11. BIRTHPLACE (State or foreign country) <u>Easton, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <u>Charles W. Holland</u>				14. MOTHER'S MAIDEN NAME <u>Louise Mitchell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mother</u> Address <u>Preston Md R 2D #1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia of middle lobe.</u> <u>493X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>7:30</u> p.m. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u>				M.D. <u>2795 Washington St. 9 Feb 59</u>			
PHYSICIAN'S NAME (Type) <u>E.C.H. Schmidt</u>				ADDRESS <u>Easton 16, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/10/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hammock Cem.</u>		22d. LOCATION (City, town, or county) <u>Preston</u> (State) <u>md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Dasher, Catonsville</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 16 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

2080284XV6

CERTIFICATE OF DEATH

Exp. Oct. 11, 1918

1. NAME OF DECEASED [Blank]		2. SEX [Blank]	
3. AGE [Blank]		4. DATE OF BIRTH [Blank]	
5. PLACE OF BIRTH [Blank]		6. PLACE OF DEATH [Blank]	
7. OCCUPATION [Blank]		8. CAUSE OF DEATH [Blank]	
9. MEDICAL HISTORY [Blank]		10. POST-MORTEM [Blank]	
11. SIGNATURE OF PHYSICIAN [Blank]		12. SIGNATURE OF REGISTRAR [Blank]	
13. DATE OF DEATH [Blank]		14. TIME OF DEATH [Blank]	
15. PLACE OF INTERMENT [Blank]		16. NAME OF FUNERAL HOME [Blank]	
17. NAME OF FUNERAL HOME [Blank]		18. NAME OF FUNERAL HOME [Blank]	
19. NAME OF FUNERAL HOME [Blank]		20. NAME OF FUNERAL HOME [Blank]	
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91. NAME OF FUNERAL HOME [Blank]		92. NAME OF FUNERAL HOME [Blank]	
93. NAME OF FUNERAL HOME [Blank]		94. NAME OF FUNERAL HOME [Blank]	
95. NAME OF FUNERAL HOME [Blank]		96. NAME OF FUNERAL HOME [Blank]	
97. NAME OF FUNERAL HOME [Blank]		98. NAME OF FUNERAL HOME [Blank]	
99. NAME OF FUNERAL HOME [Blank]		100. NAME OF FUNERAL HOME [Blank]	



THIS CERTIFICATE IS VALID FOR THE PURPOSE OF REGISTERING DEATHS IN THE STATE OF MARYLAND FOR THE YEAR 1918.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2328

CERTIFICATE OF DEATH

2319

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. LENGTH OF STAY IN 1b <u>4 da.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Michaels</u>	
f. STREET ADDRESS <u>1</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Giles</u> Middle <u>Hicks</u> Last <u>Jump</u>		4. DATE OF DEATH Month <u>2</u> Day <u>11</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 1, 1884</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR: Months <u>7</u> Days <u>11</u> Hours <u>19</u> Min. <u>59</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Jump</u>		14. MOTHER'S MAIDEN NAME <u>Martha Marshall</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>1</u>	
17. INFORMANT <u>Address</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Disease</u> <u>260X</u> DUE TO <u>Hypertensive Cardio Vascular Dis.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Deafness</u> DUE TO <u>Politis</u> (c) <u>300</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 1</u> , 19 <u>59</u> , to <u>Feb 11</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Feb 11</u> , 19 <u>59</u> , and that death occurred at <u>9:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Box 457, St. Michaels, Md.</u> DATE SIGNED <u>2-11-59</u>			
ACTUAL SIGNATURE <u>R. Lane Worth</u> M.D.		PHYSICIAN'S NAME (Type) <u>R. Lane Worth</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>2/14/59</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>Olivet</u>	22d. LOCATION (City, town, or county) (State) <u>St. Michaels, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Roman D. Marshall</u> ADDRESS <u>St. Michaels</u>		24a. REC'D BY REGISTRAR <u>FEB 17 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2329

CERTIFICATE OF DEATH

Reg. Dist. No.

02320

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>				c. LENGTH OF STAY IN 1b <u>11 da.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Joseph Alvin LOMAX</u>				4. DATE OF DEATH Month Day Year <u>February 13 1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 15 1873</u>	9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>Mr. Silas W. LOMAX</u>				14. MOTHER'S MAIDEN NAME <u>Jane Marshall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Calvin Lomax Easton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>550.1 Congestive Heart failure</u> DUE TO (b) <u>Surgery</u> DUE TO (c) <u>Ruptured appendicitis</u> INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u> <u>2/1/59</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2/2/59</u> 19 <u>59</u> , to <u>2/13</u> 19 <u>59</u> , that I last saw the deceased alive on <u>2/13</u> 19 <u>59</u> , and that death occurred at <u>8:10 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Easton Md.</u> DATE SIGNED ACTUAL SIGNATURE <u>J. T. B. Ambler</u> M.D. <u>J. T. B. AMBLER</u> <u>EASTON, Md.</u> PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-16-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Christ Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>St. Michaels Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>J. Hamilton Harrison, St. Michaels Md</u>				24a. REC'D BY REGISTRAR DATE <u>EB 19 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

10 OCT-1964

1. NAME OF DECEASED JAMES EARL RAY		2. SEX M		3. AGE 35		4. DATE OF BIRTH 12 JAN 1929	
5. PLACE OF BIRTH MOBILE, ALABAMA		6. OCCUPATION None		7. MARITAL STATUS Single		8. RACE White	
9. DATE OF DEATH 4 APR 1968		10. TIME OF DEATH 12:00 PM		11. PLACE OF DEATH MEMPHIS, TENNESSEE		12. CAUSE OF DEATH FIRE	
13. MANNER OF DEATH Suicide		14. SIGNATURE OF DECEASED JAMES EARL RAY		15. SIGNATURE OF WITNESS JAMES EARL RAY		16. SIGNATURE OF PHYSICIAN JAMES EARL RAY	
17. SIGNATURE OF CORONER JAMES EARL RAY		18. SIGNATURE OF JURY JAMES EARL RAY		19. SIGNATURE OF JUDGE JAMES EARL RAY		20. SIGNATURE OF CLERK JAMES EARL RAY	

10 OCT-1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2330

CERTIFICATE OF DEATH

02321

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY TALBOT					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON				c. LENGTH OF STAY IN 1b 2 wks.					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSP.				d. STREET ADDRESS NEWCOMB					
3. NAME OF DECEASED (Type or print) ELWOOD First NELSON Middle MARSHALL Last				4. DATE OF DEATH FEBRUARY 11 1959 Month 11 Day 1959 Year					
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1895 NOVEMBER 17, 1895			
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR 63 Months		IF UNDER 24 HRS. 63 Days		Hours 63 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STOCK ROOM CLERK				10b. KIND OF BUSINESS OR INDUSTRY EASTON WHOLESALE					
11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A					
13. FATHER'S NAME FRANK				14. MOTHER'S MAIDEN NAME NETTIE BURROWS					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 212-10-6562					
17. INFORMANT Wife				Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) atherosclerotic cardiovascular d. DUE TO (c) Diabetes mellitus, peripheral vascular occlusive d.								INTERVAL BETWEEN ONSET AND DEATH 2 wks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus, peripheral vascular occlusive d.								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)					
21. I certify that I attended the deceased from Aug , 1954, to 2-11 , 1959, that I last saw the deceased alive on 2-11 , 1959, and that death occurred at 3 A M, from the causes and on the date stated above.									
ACTUAL SIGNATURE Thy M. Beeser M.D.				ADDRESS (Street, city or town, state) St. Michaels Md					
PHYSICIAN'S NAME (Type) Thy M. Beeser				DATE SIGNED 2-11-59					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-13-59		22c. NAME OF CEMETERY OR CREMATORY Clint Cemetery		22d. LOCATION (City, town, or county) (State) St. Michaels. Md			
23. FUNERAL DIRECTOR'S SIGNATURE St. Hamilton Harrison ADDRESS St. Michaels. Md.				24a. REC'D BY REGISTRAR FEB 16 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

CERTIFICATE OF DEATH

1930

PLACE OF BIRTH		DATE OF BIRTH	
MARRIAGE		DATE OF MARRIAGE	
PLACE OF DEATH		DATE OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
EDUCATION		OCCUPATION	
RELIGION		RACE	
SEX		COLOR	
HEIGHT		WEIGHT	
TEMPERATURE		PULSE	
BLOOD PRESSURE		RESPIRATION	
DIAGNOSIS		TREATMENT	
HISTORY		FAMILY HISTORY	
SOCIAL HISTORY		HABITS	
DIET		EXERCISE	
SMOKING		ALCOHOL	
DRUGS		OTHER	
SIGNATURE OF PHYSICIAN		DATE	
SIGNATURE OF WITNESS		DATE	
SIGNATURE OF DEATH REGISTRAR		DATE	
SIGNATURE OF CLERK		DATE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 **MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

Item 2 Film G239 2-20-59 et

2340

CERTIFICATE OF DEATH

Reg. Dist. No.

02322

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY Talbot ?	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural St. Michaels		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural / St. Michaels Markham	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rio Vista Nursing Home		d. STREET ADDRESS --- 83X-3	
3. NAME OF DECEASED (Type or print) SUSAN A. MARSHALL		4. DATE OF DEATH Month Feb. Day 5. Year 19 59	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 27, 1867
9. AGE (In years last birthday) 91 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Thomas Marshall		14. MOTHER'S MAIDEN NAME Courtenay Norton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Dulaney F. DeButts		Address Easton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial failure DUE TO 492X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) pneumonia DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) atherosclerotic cardiovascular d.			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-27 , 1956 , to 2-5 , 1959 , that I last saw the deceased alive on 2-5 , 1959 , and that death occurred at 12:30 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Guy M. Reeser, Jr.		ADDRESS (Street, city or town, state) St. Michaels, Md.	
PHYSICIAN'S NAME (Type) Dr. Guy M. Reeser, Jr.		DATE SIGNED 2-6-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal & Burial Feb. 8, 1959		22b. DATE THEREOF Feb. 8, 1959	
22c. NAME OF CEMETERY OR CREMATORY Leeds Cemetery		22d. LOCATION (City, town, or county) (State) Hume, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newham & Son		24a. REC'D BY REGISTRAR FEB 10 '59	
ADDRESS Easton, Md.		24b. REGISTRAR'S SIGNATURE Arthur J. ...	

CERTIFICATE OF DEATH

2340

1. NAME OF DECEASED JAMES H. JONES		2. SEX Male		3. AGE 5 yrs	
4. PLACE OF BIRTH Maryland		5. DATE OF BIRTH Jan 1, 1925		6. PLACE OF DEATH Baltimore, Md.	
7. OCCUPATION None		8. CAUSE OF DEATH Sudden		9. MANNER OF DEATH Natural	
10. SIGNATURE OF PHYSICIAN J. H. Jones		11. SIGNATURE OF REGISTRAR J. H. Jones		12. SIGNATURE OF WITNESS J. H. Jones	
13. DATE OF DEATH Jan 1, 1925		14. TIME OF DEATH 10:00 AM		15. PLACE OF INTERMENT None	
16. NAME OF FUNERAL HOME None		17. NAME OF CEMETERY None		18. NAME OF MINISTER None	
19. NAME OF CLERGYMAN None		20. NAME OF CHURCH None		21. NAME OF SOCIETY None	
22. NAME OF ORDER None		23. NAME OF LODGE None		24. NAME OF GUILD None	
25. NAME OF ASSOCIATION None		26. NAME OF CLUB None		27. NAME OF SOCIETY None	
28. NAME OF ORDER None		29. NAME OF LODGE None		30. NAME OF GUILD None	
31. NAME OF ASSOCIATION None		32. NAME OF CLUB None		33. NAME OF SOCIETY None	
34. NAME OF ORDER None		35. NAME OF LODGE None		36. NAME OF GUILD None	
37. NAME OF ASSOCIATION None		38. NAME OF CLUB None		39. NAME OF SOCIETY None	
40. NAME OF ORDER None		41. NAME OF LODGE None		42. NAME OF GUILD None	
43. NAME OF ASSOCIATION None		44. NAME OF CLUB None		45. NAME OF SOCIETY None	
46. NAME OF ORDER None		47. NAME OF LODGE None		48. NAME OF GUILD None	
49. NAME OF ASSOCIATION None		50. NAME OF CLUB None		51. NAME OF SOCIETY None	
52. NAME OF ORDER None		53. NAME OF LODGE None		54. NAME OF GUILD None	
55. NAME OF ASSOCIATION None		56. NAME OF CLUB None		57. NAME OF SOCIETY None	
58. NAME OF ORDER None		59. NAME OF LODGE None		60. NAME OF GUILD None	
61. NAME OF ASSOCIATION None		62. NAME OF CLUB None		63. NAME OF SOCIETY None	
64. NAME OF ORDER None		65. NAME OF LODGE None		66. NAME OF GUILD None	
67. NAME OF ASSOCIATION None		68. NAME OF CLUB None		69. NAME OF SOCIETY None	
70. NAME OF ORDER None		71. NAME OF LODGE None		72. NAME OF GUILD None	
73. NAME OF ASSOCIATION None		74. NAME OF CLUB None		75. NAME OF SOCIETY None	
76. NAME OF ORDER None		77. NAME OF LODGE None		78. NAME OF GUILD None	
79. NAME OF ASSOCIATION None		80. NAME OF CLUB None		81. NAME OF SOCIETY None	
82. NAME OF ORDER None		83. NAME OF LODGE None		84. NAME OF GUILD None	
85. NAME OF ASSOCIATION None		86. NAME OF CLUB None		87. NAME OF SOCIETY None	
88. NAME OF ORDER None		89. NAME OF LODGE None		90. NAME OF GUILD None	
91. NAME OF ASSOCIATION None		92. NAME OF CLUB None		93. NAME OF SOCIETY None	
94. NAME OF ORDER None		95. NAME OF LODGE None		96. NAME OF GUILD None	
97. NAME OF ASSOCIATION None		98. NAME OF CLUB None		99. NAME OF SOCIETY None	
100. NAME OF ORDER None		101. NAME OF LODGE None		102. NAME OF GUILD None	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.—Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE

2341

CERTIFICATE OF DEATH

02324

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Trappe		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Trappe	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Main St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOSEPH Middle ENNIS Last PERCY		4. DATE OF DEATH Month Feb. Day 22, Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 4, 1880
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retail merchant		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Joseph B. Percy		14. MOTHER'S MAIDEN NAME Mary V. Hurley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-05-6236	
17. INFORMANT Mrs. Blanche Percy		Address Trappe, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Myeloma - 203X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none			INTERVAL BETWEEN ONSET AND DEATH 1 1/2 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August , 19 57 , to 2-22 , 19 59 , that I last saw the deceased alive on 2-22 , 19 59 , and that death occurred at 8:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE William L. Winters		ADDRESS (Street, city or town, state) DATE SIGNED 2-23-59	
PHYSICIAN'S NAME (Type) Dr. Wm L. Winters		Dover St. Easton, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 24, 1959	
22c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		22d. LOCATION (City, town, or county) (State) Hillsboro, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam & Son		ADDRESS Easton, Md.	
24a. REC'D BY REGISTRAR DATE FEB 25 1959		24b. REGISTRAR'S SIGNATURE Arthur J. King	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2331

CERTIFICATE OF DEATH

Reg. Dist. No.

02323

1. PLACE OF DEATH o. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalburg</u> 05X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial</u>		d. STREET ADDRESS <u>120 BLOOMINGDALE AVENUE</u>	
3. NAME OF DECEASED (Type or print) First <u>Almira</u> Middle <u>Rosser</u> Last <u>Pooler</u>		4. DATE OF DEATH Month <u>February</u> Day <u>7</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 13, 1924</u>
9. AGE (In years last birthday) <u>34</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>34</u> Days <u>34</u> Hours <u>34</u> Min. <u>34</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>USA - Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>MR. J. Edwin Rosser</u>		14. MOTHER'S MAIDEN NAME <u>Irene S. Carroll</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mr. Thomas J. Pooler (husband)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning, left leg</u> <u>345X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Multiple sclerosis.</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>19</u> to <u>19</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>9:15 P.M.</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u>		M.D. <u>219 S. Washington St.</u> <u>9 Feb 59</u>	
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>		<u>Easton 16, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>FEBRUARY 10, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>HILLCREST CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>FEDERALSBURG, MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Frampton & Son, Federalburg, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 11 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02325

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Queen Anne				c. LENGTH OF STAY IN lb 5 yrs.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Queen Anne			
				f. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last Elizabeth M. Hopkins Rhodes				4. DATE OF DEATH Month Day Year 2/25/59 19			
5. SEX F.		6. COLOR OR RACE W.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/17/78	
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME William Hopkins.				14. MOTHER'S MAIDEN NAME Rebecca Cooper.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs. Thomas Koeneman, Queen Anne	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Arteriosclerotic C-V-D Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 14 hrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Lewis Welch				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) WELCH				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/28/59		22c. NAME OF CEMETERY OR CREMATORY St. Josephs.		22d. LOCATION (City, town, or county) (State) Cordova, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Kraus				24a. REC'D BY REGISTRAR DATE FEB 27 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
JAMES H. HILL		45		M		W		JAN 15 1927	
RESIDENCE		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER	
1234 Main St.		Home		Heart Disease		Natural		J. H. Smith	
OCCUPATION		EDUCATION		RELIGION		MARITAL STATUS		SIGNED	
Teacher		High School		Catholic		Married		J. H. Smith	
PREVIOUS ILLNESS		DATE OF ONSET		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH	
None		Jan 10		Jan 15		10:00 AM		Home	
TEMPERATURE		PULSE		RESPIRATIONS		BLOOD PRESSURE		SIGNED	
101.0		90		20		120/80		J. H. Smith	
WEIGHT		HEIGHT		BUILD		COMPLEXION		SIGNED	
150 lbs		5' 8"		Medium		Fair		J. H. Smith	
DISEASES OF PRESENT ILLNESS		DISEASES OF PREVIOUS ILLNESS		DISEASES OF PRESENT ILLNESS		DISEASES OF PREVIOUS ILLNESS		SIGNED	
None		None		None		None		J. H. Smith	
SIGNATURE OF EXAMINER		DATE OF EXAMINATION		TIME OF EXAMINATION		PLACE OF EXAMINATION		SIGNED	
J. H. Smith		Jan 15		10:00 AM		Home		J. H. Smith	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Disf. No.

02326

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Near Easton (rural)</u>	c. LENGTH OF STAY IN 1b <u>20 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Near Easton (rural)</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>STEVEN Michael JANGER</u>		4. DATE OF DEATH Month Day Year <u>FEB. 27 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 5, 1959</u>
9. AGE (In years last birthday) yrs. <u>22</u>		IF UNDER 1 YEAR Months <u>22</u> Days <u>22</u> Hours <u>22</u> Min. <u>22</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Arthur Janger</u>		14. MOTHER'S MAIDEN NAME <u>Anita L. Howe</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mr. Arthur Janger</u>		Address <u>Easton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Tracheo-bronchitis</u> <u>501x</u> DUE TO (b) <u>URI.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>due to</u>		INTERVAL BETWEEN ONSET AND DEATH <u>days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Louis Mundy</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>WELTV</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>2-27-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 1, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cordova Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice E. Newman</u>		24a. REC'D BY REGISTRAR <u>MAR 2 '59</u>	
ADDRESS <u>501 Easton, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Howe</u>	

2080213XV5

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2344

CERTIFICATE OF DEATH

Reg. Dist. No.

02327

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SHERWOOD</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Addie</u> Middle <u>J.</u> Last <u>Schehls</u>				4. DATE OF DEATH Month <u>FEB</u> Day <u>4</u> Year <u>1959</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 5, 1884</u>	9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>		IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>St. Michaels, md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>James E. Plummer</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Letourneau</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Robert T. Schelle, St. Michaels, md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>atherosclerotic cardiovascular d.</u> (c) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive C.V.D., chronic cardiac failure</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>St. Michaels, md</u>				20g. (County) <u>md</u>			
20h. (State) <u>md</u>							
21. I certify that I attended the deceased from <u>10-22-1954</u> , to <u>3-5-1959</u> , that I last saw the deceased alive on <u>1-24-1959</u> , and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>St. Michaels, md</u> DATE SIGNED <u>2-6-59</u>							
ACTUAL SIGNATURE <u>Thy M. Reeser, Jr.</u>				M.D. <u>St. Michaels, md</u>			
PHYSICIAN'S NAME (Type) <u>Thy M. Reeser, Jr.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>FEB. 7, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Christ Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>St. Michaels, md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hamilton Harrison, St. Michaels, md</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2332

CERTIFICATE OF DEATH

Reg. Dist. No.

02328

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MARYDEL</u>			
c. LENGTH OF STAY IN 1b <u>5 da</u>				d. STREET ADDRESS <u>NONE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Theodore</u> Middle <u>H.</u> Last <u>SOWADA</u>				4. DATE OF DEATH Month <u>2</u> Day <u>22</u> Year <u>1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Apr. 20, 1893</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>GERMANY</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>John Sowada</u>				14. MOTHER'S MAIDEN NAME <u>Albina Kiwus</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NOIVE</u>		17. INFORMANT Address <u>ELIZABETH SOWADA MARYDEL MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>apoplexy</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>a c v d</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1 Parkinson's Paralysis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb 17, 1959</u> , to <u>Feb 22, 1959</u> , that I last saw the deceased alive on <u>Feb 22</u> , 19 <u>59</u> , and that death occurred at <u>8 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>[Signature]</u> M.D. _____							
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>2/24/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross</u>		22d. LOCATION (City, town, or county) (State) <u>Flower, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Boelens</u> ADDRESS <u>Steensters, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 25 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital, or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2333

CERTIFICATE OF DEATH

Reg. Dist. No.

02329

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>6 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Queen Anne</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Grace</u> Middle <u>Stevens</u> Last				4. DATE OF DEATH Month <u>February</u> Day <u>14</u> Year <u>1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 30, 1892</u> 76 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		9. AGE (In years last birthday) <u>76</u>	
11. BIRTHPLACE (State or foreign country) <u>Delaware</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>John H. Dyer</u>				14. MOTHER'S MAIDEN NAME <u>Ida Morris</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>220-32-0370</u>		17. INFORMANT <u>Mrs. George Sharp</u> Address <u>Centerville Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Cardiac failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial infarction</u> (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u> <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Feb 14</u> , 19 <u>59</u> , to <u>Feb 14</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Feb 14</u> , 19 <u>59</u> , and that death occurred at <u>2:55 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thurston Harrison</u> M.D.				ADDRESS (Street, city or town, state) <u>Easton, Maryland</u> DATE SIGNED <u>16 Feb 59</u>			
PHYSICIAN'S NAME (Type) <u>THURSTON HARRISON</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-17-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Easton, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice L. Neumann</u> ADDRESS <u>Easton, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE FEB 19 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2345

CERTIFICATE OF DEATH

02330

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Michaels		c. LENGTH OF STAY IN 1b 14X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rio Vista Nursing Home		d. STREET ADDRESS Rock Hall	
3. NAME OF DECEASED (Type or print) First Middle Last Ovilla Stevens		4. DATE OF DEATH Month Day Year 2 20 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-18-1863
9. AGE (In years last birthday) 96 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wesley Stevens		14. MOTHER'S MAIDEN NAME Emily Ashley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Emily Ackers--Rock Hall, md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) atherosclerotic cardio-cerebro vas. d. DUE TO (c) cardiomyopathy cachexia-severe		INTERVAL BETWEEN ONSET AND DEATH 1 mo — —	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-19-1959, to 2-20-1959, that I last saw the deceased alive on 2-20-1959, and that death occurred at 12:59 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE M.D. St Michaels Md PHYSICIAN'S NAME (Type) Guy M. Reeder Jr 2-21-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 23	
22c. NAME OF CEMETERY OR CREMATORY Wesley Chapel		22d. LOCATION (City, town, or county) (State) Rock Hall, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Kane		ADDRESS Church Hill, d.	
24a. REC'D BY REGISTRAR DATE FEB 27 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kenna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2334

CERTIFICATE OF DEATH

02331

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greensboro</u> 05x-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hosp.</u>				d. STREET ADDRESS <u>Denton Road.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>(ms) Barnice Evelyn Strauderman</u>				4. DATE OF DEATH Month Day Year <u>2 - 28 19 59</u>			
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 3 1909</u>	
9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTH PLACE (State or foreign country) <u>Ohio</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Herman Roddy</u>				14. MOTHER'S MAIDEN NAME <u>Bessie</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>#218-224718</u>		17. INFORMANT <u>Robin Strauderman, son.</u> Address <u>501 Shamrock Lane Pikesville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Masacre intra-partine hemmorage</u> <u>331x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>219 S. Washington St 2810159</u> DATE SIGNED ACTUAL SIGNATURE <u>E C H Schmidt</u> M.D. <u>Easton 16 Maryland.</u> PHYSICIAN'S NAME (Type) <u>E C H Schmidt</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 3, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn</u>		22d. LOCATION (City, town, or county) (State) <u>Akron, Ohio</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John O. Mitchell - Sons</u> ADDRESS <u>Baltimore, Md. 1900 Eutaw Place</u>				24a. REGISTRY REGISTRAR DATE <u>MAR 3 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

CERTIFICATE OF DEATH

1933

Reg. Dist. No.

1. NAME OF DECEASED <i>John A. Smith</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Jan 15 1933</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. DISEASE OR INJURY <i>Myocardial Infarction</i>		9. MANNER OF DEATH <i>Natural</i>	
10. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Jones</i>		11. SIGNATURE OF REGISTRAR <i>John A. Smith</i>		12. SIGNATURE OF WITNESSES <i>John A. Smith, Mary A. Smith</i>	
13. DATE OF BURIAL <i>Jan 17 1933</i>		14. TIME OF BURIAL <i>11:00 AM</i>		15. PLACE OF BURIAL <i>St. John's Church</i>	
16. NAME OF BURIAL PLACE <i>St. John's Church</i>		17. NAME OF MINISTER <i>Rev. J. H. Jones</i>		18. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>	
19. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>		20. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>		21. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>	
22. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>		23. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>		24. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>	
25. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>		26. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>		27. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>	
28. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>		29. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>		30. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>	
31. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>		32. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>		33. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>	
34. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>		35. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>		36. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>	
37. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>		38. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>		39. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>	
40. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>		41. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>		42. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>	
43. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>		44. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>		45. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>	
46. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>		47. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>		48. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>	
49. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>		50. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>		51. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>	
52. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>		53. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>		54. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>	
55. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>		56. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>		57. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>	
58. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>		59. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>		60. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>	
61. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>		62. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>		63. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>	
64. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>		65. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>		66. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>	
67. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>		68. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>		69. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>	
70. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>		71. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>		72. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>	
73. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>		74. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>		75. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>	
76. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>		77. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>		78. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>	
79. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>		80. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>		81. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>	
82. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>		83. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>		84. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>	
85. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>		86. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>		87. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>	
88. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>		89. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>		90. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>	
91. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>		92. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>		93. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>	
94. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>		95. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>		96. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>	
97. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>		98. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>		99. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>	
100. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>		101. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>		102. NAME OF DECEASED'S RELATIVES <i>John A. Smith, Mary A. Smith</i>	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BACHTER 13

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>DORCHESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>				c. LENGTH OF STAY IN 1b <u>14 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HURLOCK</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MEMORIAL</u>				d. STREET ADDRESS <u>FRONT STREET</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>SARAH</u> Middle <u>LYNN</u> Last <u>TAYLOR</u>				4. DATE OF DEATH Month <u>FEBRUARY</u> Day <u>26</u> Year <u>1959</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCTOBER 28, 1908</u>	
9. AGE (In years last birthday) yrs. <u>51</u>		IF UNDER 1 YEAR Months <u>3</u> Days <u>28</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>NO DATA</u>	
14. MOTHER'S MAIDEN NAME <u>PATRICIA ANN TAYLOR</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>MOTHER</u> Address <u>HURLOCK, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia of lung</u> <u>519.2</u> DUE TO <u>Hydrothorax, rt.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>11:50 p.m.</u> , 19 <u>59</u> , to <u>11:50 p.m.</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11:50 p.m.</u> , 19 <u>59</u> , and that death occurred at <u>11:50 p.m.</u> , 19 <u>59</u> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u> M.D.				DATE SIGNED <u>219 S. Washington St. 27 March 59</u>			
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>				ADDRESS (Street, city or town, state) <u>Easton 16, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MARCH 1, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WASHINGTON CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>NEAR HURLOCK, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Trampton Son</u>				ADDRESS <u>Federalburg md.</u>		24a. REC'D BY REGISTRAR <u>DATE MAR 6 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

2082101XV3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02333

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

2336

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton.</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 Easton.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lawrence Christopher Thomas</u>				4. DATE OF DEATH Month Day Year <u>February 11 1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>December 8, 1958</u>	
9. AGE (in years last birthday) yrs. <u>2</u> Months <u>3</u> Days <u>3</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Harvey Lee Thomas, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Harris</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mother - Easton.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sub-dural hemorrhage</u> <u>351X</u> DUE TO (b) <u>Fracture right parietal bone.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Louis Welch</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>LOUIS WELCH</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>2-16-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>2/14/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Richards Cmn.</u>		22d. LOCATION (City, town, or county) (State) <u>Easton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. DeShull</u>				ADDRESS <u>Easton, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 24 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

2346

CERTIFICATE OF DEATH

Reg. Dist. No.

02334

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wittman		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First OGLE Middle THOMAS Last THOMAS		4. DATE OF DEATH Month February Day 25 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 30, 1886
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months 72 Days 72 Hours 72 Min. 72	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Seafood	
11. BIRTHPLACE (State or foreign country) Wittman, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Thomas		14. MOTHER'S MAIDEN NAME Hettie Marshall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I 219-14-3086	
17. INFORMANT Ernest A. Harrison, Easton, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO 10 yrs. DUE TO 10 yrs.		INTERVAL BETWEEN ONSET AND DEATH 6 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) RT inguinal Hernia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 25 Feb , 19 59 , to 25 Feb , 19 59 , that I last saw the deceased alive on 25 Feb , 19 59 , and that death occurred at 2:30 P. M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED 2-26-59	
ACTUAL SIGNATURE R. Hamilton Harrison M.D.		PHYSICIAN'S NAME (Type) R. Hamilton Harrison	
22a. BURIAL, CREMATION, or OTHER (Specify) Burial		22b. DATE THEREOF Feb 28, 1959	
22c. NAME OF CEMETERY OR CREMATORY Olivet Cemetery		22d. LOCATION (City, town, or county) (State) St. Michaels, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE R. Hamilton Harrison		ADDRESS St. Michaels	
24a. REC'D BY REGISTRAR DATE MAR 2 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 could be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2337

CERTIFICATE OF DEATH

02335

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>David</u> Middle <u>Townsend</u> Last <u>Townsend</u>				4. DATE OF DEATH Month <u>February</u> Day <u>2</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 25, 1897</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Townsend</u>				14. MOTHER'S MAIDEN NAME <u>Frances Kellum</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Perforated gastric ulcer</u> <u>540.1</u> <u>due to</u> <u>anxiety</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>anxiety</u> (c) <u>anxiety</u> INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u>19</u> Day <u>19</u> Year <u>1959</u> Hour <u>a. m.</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Easton</u>				20g. (County) <u>Talbot</u>		20h. (State) <u>Maryland</u>	
21. I certify that I attended the deceased from <u>1959</u> to <u>1959</u> , that I last saw the deceased alive on <u>1959</u> and that death occurred at <u>11:40 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2195 Washington St. Easton, Md.</u> DATE SIGNED <u>2 Feb 59</u>							
ACTUAL SIGNATURE <u>E. C. H. Schmitt</u>				PHYSICIAN'S NAME (Type) <u>E. C. H. Schmitt</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-7-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Unionville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Easton, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Doshier</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 16 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

MAYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2347

CERTIFICATE OF DEATH

Reg. Dist. No.

02336

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Neavitt			c. LENGTH OF STAY IN 1b 3 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Neavitt		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GEORGE Middle ELLIS Last WHITE				4. DATE OF DEATH Month Feb. Day 6, Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 9, 1895	
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) yard superintendent				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
						12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Walter White				14. MOTHER'S MAIDEN NAME Dollie Jamison			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 215-03-8229		17. INFORMANT Address Mrs. G. E. White Neavitt, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Coronary Artery Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 30 min 347						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6 Feb , 19 59 , to 6 Feb , 19 59 , that I last saw the deceased alive on 6 Feb , 19 59 , and that death occurred at 6:15 M, from the causes and on the date stated above. ACTUAL SIGNATURE R. Lane Wroth M.D. ADDRESS (Street, city or town, state) Box 487, St. Michaels, Md DATE SIGNED 2-9-59 PHYSICIAN'S NAME (Type) Dr. R. Lane Wroth St. Michaels, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 9, 1959		22c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial Park		22d. LOCATION (City, town, or county) (State) Elkridge, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam & Son				ADDRESS Easton, Md.		24a. REC'D BY REGISTRAR DATE FEB 10 '59	
						24b. REGISTRAR'S SIGNATURE Carlton S. H.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02337

2348

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Florida b. COUNTY Jacksonville	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Michaels		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jacksonville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rio Vista Nursing Home		d. STREET ADDRESS 124 East 6th St.	
3. NAME OF DECEASED (Type or print) First BERTHA Middle ESTELLE Last WILLIAMS		4. DATE OF DEATH Month Feb. Day 9 Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 7, 1898
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) nurse		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Florida		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Wm M. Anderson		14. MOTHER'S MAIDEN NAME Alice Bickford	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Grace Doss		Address St. Michaels, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cocheria - severe - general 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) adenocarcinomatosis - general - metastatic DUE TO (c) adenocarcinoma colon		INTERVAL BETWEEN ONSET AND DEATH - 2 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. ft. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-25 , 19 58 , to 2-9 , 19 59 , that I last saw the deceased alive on 2-9 , 19 59 , and that death occurred at 7:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) St. Michaels, Md. DATE SIGNED 2-10-59			
ACTUAL SIGNATURE Guy M. Reeser, Jr.		M.D. 2-10-59	
PHYSICIAN'S NAME (Type) Dr. Guy M. Reeser, Jr.		St. Michaels, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF Feb. 13, 1959	
22c. NAME OF CEMETERY OR CREMATORY Riverside Memorial Park		22d. LOCATION (City, town, or county) (State) Jacksonville, Florida	
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam & Son		ADDRESS Easton, Md.	
24a. REC'D BY REGISTRAR DATE FEB 13 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Knaus	

THIS CERTIFICATE IS TO BE FILLED OUT BY THE PHYSICIAN OR OTHER PERSON QUALIFIED TO MAKE A MEDICAL JUDGMENT AS TO THE CAUSE OF DEATH. IT IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, WHO WILL TRANSMIT IT TO THE BUREAU OF VITAL STATISTICS. IT IS NOT TO BE USED FOR ANY OTHER PURPOSE.

1. NAME OF DECEASED		2. SEX		3. AGE	
JAMES H. HARRIS		Male		45	
4. DATE OF DEATH		5. PLACE OF DEATH		6. TIME OF DEATH	
April 15, 1934		Home		10:30 A.M.	
7. PLACE OF BIRTH		8. DATE OF BIRTH		9. PLACE OF BIRTH	
New York City		April 15, 1889		New York City	
10. OCCUPATION		11. MARITAL STATUS		12. EDUCATION	
Teacher		Married		High School	
13. CAUSE OF DEATH		14. MANNER OF DEATH		15. SIGNATURE OF PHYSICIAN	
Heart Disease		Natural		J. H. Harris	
16. SIGNATURE OF REGISTRAR		17. SIGNATURE OF WITNESSES		18. SIGNATURE OF DECEASED	
J. H. Harris		J. H. Harris		J. H. Harris	
19. SIGNATURE OF DECEASED		20. SIGNATURE OF DECEASED		21. SIGNATURE OF DECEASED	
J. H. Harris		J. H. Harris		J. H. Harris	
22. SIGNATURE OF DECEASED		23. SIGNATURE OF DECEASED		24. SIGNATURE OF DECEASED	
J. H. Harris		J. H. Harris		J. H. Harris	
25. SIGNATURE OF DECEASED		26. SIGNATURE OF DECEASED		27. SIGNATURE OF DECEASED	
J. H. Harris		J. H. Harris		J. H. Harris	
28. SIGNATURE OF DECEASED		29. SIGNATURE OF DECEASED		30. SIGNATURE OF DECEASED	
J. H. Harris		J. H. Harris		J. H. Harris	
31. SIGNATURE OF DECEASED		32. SIGNATURE OF DECEASED		33. SIGNATURE OF DECEASED	
J. H. Harris		J. H. Harris		J. H. Harris	
34. SIGNATURE OF DECEASED		35. SIGNATURE OF DECEASED		36. SIGNATURE OF DECEASED	
J. H. Harris		J. H. Harris		J. H. Harris	
37. SIGNATURE OF DECEASED		38. SIGNATURE OF DECEASED		39. SIGNATURE OF DECEASED	
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97. SIGNATURE OF DECEASED		98. SIGNATURE OF DECEASED		99. SIGNATURE OF DECEASED	
J. H. Harris		J. H. Harris		J. H. Harris	
100. SIGNATURE OF DECEASED		101. SIGNATURE OF DECEASED		102. SIGNATURE OF DECEASED	
J. H. Harris		J. H. Harris		J. H. Harris	

CERTIFICATE OF DEATH

2332

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2338

CERTIFICATE OF DEATH

Reg. Dist. No.

02338

1. PLACE OF DEATH o. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hosp.</u>				d. STREET ADDRESS <u>RT. #2 Box 10</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ella HARRISON Willson</u>				4. DATE OF DEATH Month Day Year <u>February 10 1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 11, 1895</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Housekeeper</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William J. Harrison</u>				14. MOTHER'S MAIDEN NAME <u>Annie Williams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>J. Bartlett Tucker</u>				Address <u>Easton Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>420.1</u> DUE TO <u>Arteriosclerotic coronary thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>5 p.m.</u> , 19 <u>59</u> , to <u>10 Feb</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9 Feb</u> , 19 <u>59</u> , and that death occurred at <u>12:30 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thurston Harrison</u>				ADDRESS (Street, city or town, state) <u>Easton Maryland</u>			
DATE SIGNED <u>10 Feb 59</u>							
PHYSICIAN'S NAME (Type) <u>THURSTON HARRISON</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb 17, 59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Friends Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Easton Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Tucker</u>				ADDRESS <u>Easton Md</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 13 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur E. Tucker</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

